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Barry R. Furrow
Health Law Institute

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THE PROBLEM OF THE SPORTS DOCTOR: SERVING TWO (OR IS IT THREE OR FOUR?) MASTERS

BARRY R. FURROW*

INTRODUCTION

Americans love sports. We spend millions of dollars on stadiums, gift items from team franchises, luxury box seats, and thousands of hours watching sporting events on television and at these stadiums. In 2002, it was estimated that the combined value of the teams in the NBA, NHL, MLB, and NFL was more than \$12 billion.¹ Sports is the new mass entertainment industry, as media giants generate more and more sports programming. The velocity of money moving around in professional sports has increased dramatically. For example, the average salary of a major league baseball player climbed from approximately \$76,000 in 1977 to \$2,385,000 in 2002.² Up to forty hours per week “professional team sports are beamed to home television sets by the major networks,” and hundreds of hours more by cable networks.³ Sports is big business.

Athletes are our American heroes, subject to obsessive fan worship and idealization as manifestations of the Greek ideal of the perfect citizen. We drive our children to higher and higher levels of performance excellence as part of proving that we are competitive parents. When I was growing up in the Midwest in the fifties and early sixties, we played random pickup games of baseball and basketball in elementary school. By middle school and high school, team sports were a major feature of any good public school. We adored Iowa basketball, driving long distances to see our men’s and women’s teams play in state tournaments. Sports were accessible to everyone, a commonality that could easily be shared among very different individuals. And intensity certainly surrounded sport competition, even forty years ago.

* Professor of Law and Director, the Health Law Institute, Widener University School of Law. B.A., Harvard College, J.D., Harvard Law School.

1. Soonhwan Lee & Hyosung Chun, *Economic Values of Professional Sport Franchises in the United States*, 5 SPORT J. (Fall 2002), <http://www.thesportjournal.org/2002Journal/Vol5-No3/economic-values.asp>.

2. *Id.*

3. *Id.*

The development of sports as big business, however, has taken this intensity and magnified it. Sports today is marked by characteristics that are more intensely visible than in the past. First, sports is big business, drawing in millions of commercial sponsorships and paying out millions in high salaries to star athletes in professional sports. Second, sports competition is fueled by American competitiveness, enhanced by pressures from the media and corporate sponsorships. Third, sports operates at times as a metaphor for life as warfare. And finally, from the perspective of this Article, sports can be quite dangerous, causing injuries to players and also subjecting them to stresses that may exacerbate existing injuries. The result is often intense pressure on athletes, coaches, and on team physicians. Former National Football League player Bernie Parrish has said:

The doctor is a super-fan who is part of the team. His decisions are greatly influenced by the need of the team and the desire of the patient to play. "Let him play and we'll keep a close watch on him" is too often the decision of the super-fan physician.⁴

Consider the intensity manifested by Curt Schilling's desire to pitch in the World Series in 2004, and the parallel desire of the team physician Bill Morgan to enable him to do so. Morgan developed an innovative technique of stitching down Schilling's damaged ankle tendon.⁵ The tendon was sutured temporarily into place by stitching the skin to the deep tissue below it.⁶ It was a temporary solution, with Dr. Morgan assuring Schilling that it would not damage Schilling's ankle any further.⁷ Schilling was delighted to continue to pitch, although it is certainly not clear that the risk of harm was zero. The physician demonstrated his intense commitment to do whatever it would take to keep a critical player in competition. Was this innovation without long term risks to Schilling? If the information was lacking, should the procedure have been done? Clearly, the interests of team physician, player, and team were in alignment, but against the standards of good prudent medical practice.

I. GOOD MEDICINE: THE IDEAL PHYSICIAN

An analysis of the proper functions of a sports doctor and the possible conflicts that he or she might encounter depends on a baseline standard of ideal physician conduct. The analysis traditionally starts with the role of physician as fiduciary to the patient.

4. Craig A. Isaacs, Comment, *Conflicts of Interest for Team Physicians: A Retrospective in Light of Gathers v. Loyola Marymount University*, 2 ALB. L.J. SCI. & TECH. 147, 159 (1992).

5. Steve Wilstein, *Schilling Placed Pennant Over Pain*, ESPN.COM, Oct. 23, 2004, <http://sports.espn.go.com/mlb/playoffs2004/news/story?id=1907879>.

6. *Id.*

7. *Id.*

A. *The Physician as Fiduciary*

We use the language of fiduciary law in special circumstances to define the obligations that one person owes to another. A fiduciary obligation in medicine means that the physician focuses exclusively on the patient's health; the patient assumes the doctor's single-minded devotion to him; and the doctor-patient relationship is expected to be free of conflict. Medical ethicists frequently speak of the doctor's special duties in relation to the patient, often characterizing the doctor as a special friend to the patient, connected by a bond of loyalty normally subsumed within the meaning of friendship. It is a strong agency relationship in which we trust the physician as our agent to look out for our best interests. Hans Jonas describes this duty owed by the physician to a patient as a "sacred trust," an intense obligation to ignore social and other concerns that interfere with the care of the specific patient.⁸

The ethical literature often intensifies this agency relationship, turning the "special friend" into a "warrior" on the patient's behalf—fiercely devoted, drawing upon all available resources to combat the war against the enemy—illness.⁹ While this agency model may suffer from severe limitations in the doctor-patient setting, it is clearly a correct description of the legal and cultural view of the doctor-patient relationship.¹⁰ Physicians have always been bound by fiduciary obligations, and for good reason, as the doctor-patient relationship has always been laden with conflicts of interest.¹¹

Lacking equality in the relationship, the patient is, in Judge Spottswood Robinson's phrase, "well nigh abject" in his ignorance of medicine and

8. HANS JONAS, *PHILOSOPHICAL ESSAYS: FROM ANCIENT CREED TO TECHNOLOGICAL MAN* 124 (1974).

In the course of treatment, the physician is obligated to the patient and no one else. He is not the agent of society, nor of the interests of medical science, nor of the patient's family, nor of his co-sufferers, or future sufferers from the same disease. The patient alone counts when he is under the physician's care. . . . [T]he physician is bound not to let any other interest interfere with that of the patient in being cured. But, manifestly, more sublime norms than contractual ones are involved. We may speak of a sacred trust; strictly by its terms, the doctor is, as it were, alone with his patient and God.

Id.

9. *See id.*

10. *See* David Dranove & William D. White, *Agency and the Organization of Health Care Delivery*, 24 *INQUIRY* 405 (1987).

11. A physician may be said to act as an agent for the patient in selecting appropriate specialists, hospitals, and other care providers. Under traditional agency law, the physician is therefore a fiduciary for these purposes. *See* RESTATEMENT (SECOND) OF AGENCY § 13 (1958). The general principle of loyalty owed by a fiduciary agent to a principal is described in the following terms: "Unless otherwise agreed, an agent is subject to a duty to his principal to act solely for the benefit of the principal in all matters connected with his agency." *Id.* § 387; *see also* Maxwell J. Mehlman, *Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers*, 51 *U. PITT. L. REV.* 365, 366-67 (1990) (discussing the patient-centered decision-making obligation in terms of fiduciary duty).

uncertainty about treatment.¹² The law, acknowledging this inequality, and not completely trusting physician ethics and objectivity, has created frameworks to equalize the relationship and empower the patient. The doctrine of informed consent requires that information be disclosed and that the patient consent to diagnoses and treatment. Disclosure obligations stretch beyond informed consent to include disclosure of possible economic conflicts of interest, and even in rare cases personal shortcomings of the physician independent of treatment risks, such as alcoholism or inexperience. And standing in the shadows, brooding in anticipation of failures that cause patient harm, are malpractice litigation, medical licensing boards, and hospital staff review.

We don't, in other words, completely trust our doctors. Why not? They are well and expensively trained, having given up close to a decade or more of their productive years in demanding medical study; they are professionals, socialized into high ethical standards, and are paid to look after the patients' best interests. We do not trust them without reserve because of situational pressures that may at times corrupt or at least tempt them: doctors work for economic and other gains, as we all do. They are weak at times, prey to needs and pressures not aligned with those of their patients, and they are under tremendous pressures in contexts like that of competitive sports, and particularly professional sports.

Why should a team doctor, a sport doctor, be any more able than the ordinary physician to avoid conflicts of interest? The sports doctor is in a conflict of interest situation from the moment he or she contracts to serve a sports team, whether a private team or a university collegiate sports system. Like the company doctor and the military doctor, the team doctor wants to serve his patient's best interests and also his employer's best interests. He or she is under substantial pressure, more pressure than the average family practitioner experiences with the average patient. The pressure is to ensure that the player heals well and fast, to sign off on a player's injury or an underlying cardiac condition so that the player can return to team play.

The doctor has never been an unalloyed agent for the patient, to be trusted without reservation. The physician has always had mixed motivations—to maximize income, to fit within normal practice rather than be a leader, and to get along. In this atmosphere, where the physician has ceased to be a trusted agent bound to protect the patient's interests at all costs, both physician and patient need a protective legal framework to push back against other pressures they both may feel.

Professional ethics impose fiduciary obligations on physicians, which courts convert into legal obligations. Courts often look outside the parameters of contract law analysis in judging the obligations of a physician to treat a patient, stressing that the physician's obligation to his patient, while having its

12. *Canterbury v. Spence*, 464 F.2d 772, 782 (D.C. Cir. 1972).

origins in contract, is governed also by fiduciary obligations and other public considerations “inseparable from the nature and exercise of his calling.”¹³ Doctors are not treated like businesspeople, where self-interest is expected to be the norm.¹⁴

Physicians lose a range of legal protections when they withhold information from patients. Withholding information about a medical error by the doctor is fraud in some states, a distinct cause of action.¹⁵ It also tolls the

13. Norton v. Hamilton, 89 S.E.2d 809, 812 (Ga. Ct. App. 1955) (doctor withdrew from care at time when wife was in premature labor; while husband searched for a substitute, wife delivered child); see Chatman v. Millis, 517 S.W.2d 504, 506 (Ark. 1975) (holding that malpractice action requires a doctor-patient relationship, i.e., there must be a duty owed from doctor to patient, although commenting that “[w]e do not flatly state that a cause for malpractice must be predicated upon a contractual agreement between a doctor . . . and patient”). For a history of this fiduciary duty, see generally Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451, 456-69 (2000).

14. Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 949 (1963).

It is clear from everyday observation that the behavior expected of sellers of medical care is different from that of business men in general. These expectations are relevant because medical care belongs to the category of commodities for which the product and the activity of production are identical. In all such cases, the customer cannot test the product before consuming it, and there is an element of trust in the relation. But the ethically understood restrictions on the activity of a physician are much more severe than on those of, say, a barber. His behavior is supposed to be governed by a concern for the customer's welfare which would not be expected of a salesman. In Talcott Parsons's terms, there is a “collectivity-orientation,” which distinguishes medicine and other professions from business, where self-interest on the part of participants is the accepted norm.

Id.; see also TALCOTT PARSONS, *ESSAYS IN SOCIOLOGICAL THEORY* 34-49 (rev. ed. 1954).

15. In a few jurisdictions, courts have allowed a separate intentional tort theory to be pleaded along with a negligence claim, where the physician has deliberately altered records to create misleading entries or has knowingly made a false material representation to a plaintiff. The party seeking to take advantage of a defendant's fraudulent concealment has the burden of proving that the defendant affirmatively concealed the facts upon which the cause of action is based. As one court noted, however, “The close relationship of trust and confidence between patient and physician gives rise to duties of disclosure which may obviate the need for a patient to prove an affirmative act of concealment.” Koppes v. Pearson, 384 N.W.2d 381, 386 (Iowa 1986).

An action for deceit requires proof that a false representation of a material fact was made, the false representation was relied upon by the patient in ignorance, and damage resulted. See Harris v. Penninger, 613 S.W.2d 211, 214 (Mo. Ct. App. 1981). The representation must be fraudulently made, because an intention to deceive by the physician is needed. *Id.* In *Hart v. Browne*, 163 Cal. Rptr. 356, 357-58 (Cal. Ct. App. 1980), a physician was sued for fraud when he advised the lawyer for a surgeon's patient that the surgeon's conduct was not negligent, when the records he had examined in fact showed abundant negligence. See also *Henry v. Deen*, 310 S.E.2d 326, 328 (N.C. 1984) (allowing a theory of civil conspiracy and a punitive damages claim); *Krueger v. St. Joseph's Hospital*, 305 N.W.2d 18, 25 (N.D. 1981) (allowing a claim of fraud based upon the physician's false representations).

statute of limitations in a malpractice suit by the patient against that doctor.¹⁶ An informed consent cause of action is based on failure to disclose information.¹⁷ Some newer cases are also based on a claim for a breach of a physician's fiduciary duty to disclose conflicts of interest.¹⁸ In Mark Pauly's words, "[T]he market for medical care is almost as much a market for information as it is a market for specific services."¹⁹ Athletes are particularly vulnerable consumers, poorly equipped to decide whether a medical service is critical, deferrable, or unnecessary. Nor can they decide whether the physician's treatment recommendations are generally accepted practice, something innovative, or simply a minority practice.

B. The Special Role of the Team Physician

The sports medicine physician has a more active and involved relationship with sports team members than your or my primary care physician typically has with us.²⁰ He or she must make major decisions about an athlete's health, qualifications to join a team, and ability to participate safely.²¹ These decisions have the potential to affect the success of the athlete and the success of the team, and are often made under intense time pressure.²²

The sports physician must understand the unique risk of each sport and possess an extensive medical knowledge of the musculoskeletal system, the cardio-respiratory function, neurology, psychology and behavior, pharmacology, and exercise science. Practice areas include family practice, orthopedic surgery, internal medicine, pediatrics, emergency medicine, general surgery, and cardiology.²³

Sports medicine is special because of the intensity of play, and therefore the possible severity of injuries. The possibility of severe injuries, coupled with pressures to keep athletes in play, defines the team physician's role as a special one, subject to unique and intense pressures.

16. See, e.g., *Mastro v. Brodie*, 682 P.2d 1162, 1166 (Colo. 1984) (defining "discovery" for purposes of tolling statute of limitations).

17. BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS & PROBLEMS* 366–67 (5th ed. 2004).

18. Professor Calandrillo argues that physicians must be required to disclose their conflicts of interest to the athlete–patients they treat. See Steve P. Calandrillo, *Sports Medicine Conflicts: Team Physicians vs. Athlete Patients*, 50 ST. LOUIS U. L.J. 185, 206–07 (2005).

19. Mark V. Pauly, *Is Medical Care Different? Old Questions, New Answers*, 13 J. HEALTH POL. POL'Y & L. 227, 228 (1988).

20. See Justin P. Caldarone, *Professional Team Doctors: Money, Prestige, and Ethical Dilemmas*, 9 SPORTS LAW J. 131, 145 (2002).

21. See *id.* at 142.

22. See *id.*

23. Twila Keim, *Physicians for Professional Sports Teams: Health Care Under the Pressure of Economic and Commercial Interests*, 9 SETON HALL J. SPORT L. 196, 198 (1999).

II. THE CONFLICTED REALITY OF SPORTS MEDICINE

Multiple sources of pressure impinge on physician decision-making. Players in professional sports are now getting million-dollar-plus contracts and lucrative endorsements for consumer goods. Owners are making handsome profits from at least some of the sports franchises. Coaches are also celebrities with salaries to match. The sports doctor, often an intense sports fan, gets employment with teams and direct involvement in the sport. And if the physician is part of a medical group, the group gets tremendously valuable free advertising that will draw in other patients.

Medical groups often bid for team doctor status.²⁴ The NFL's Jacksonville Jaguars, for example, advertised for the position of team physician; the winning doctor was "expected to purchase luxury boxes, pay for advertisements in game programs, and donate [medical] supplies."²⁵ A medical practice, therefore, sees sports medicine as a marketing device for drawing in other patients²⁶ and is likely to want to maintain team doctor status at any cost given its revenue generation potential.

The athletes themselves are under powerful pressures to compete well, in order to continue a lucrative career and keep younger athletes from overtaking them.²⁷ The team wants to win and wants each team member to be physically able to compete at optimal levels. An injured player, if unable to play, risks the delicate balance that often constitutes an effective team dynamic. The coach in any sport is fiercely competitive and often marked by the ethic of playing in spite of injuries as the appropriate response; his career, high income, and future employment with other teams depends on each player continuing to play.

The owner likewise has invested millions of dollars in his franchise in the expectation of success and the glory and perhaps profit that attend success. And the player's family may in some cases also be dependent on the largess of the player and want him to continue playing in order to keep up the revenue stream of professional athletics. The pressures on players to play at any cost—and therefore on their doctors to keep them in play—require strong counter pressures in order to protect both players and physicians from conduct that causes long-term patient injury.

24. Caldarone, *supra* note 20, at 145.

25. *Id.*

26. *Id.*

27. Some of these pressures are well described in Nick DiCello, Note, *No Pain, No Gain, No Compensation: Exploiting Professional Athletes Through Substandard Medical Care Administered by Team Physicians*, 49 CLEV. ST. L. REV. 507, 515–18 (2001).

III. STRATEGIES TO PROMOTE HIGH QUALITY CARE IN SPORTS MEDICINE

Just as sports has become big business, sports medicine is in the process of becoming a medical subspecialty.²⁸ And sports law is also becoming an elective subject of study in American law schools, as scholars turn their attention to the legal issues surrounding sports.²⁹ The coalescence of sports medicine into a distinct specialty with strong guidelines for good medical practice and ethical boundaries is a salutary development, as it creates a bargaining force to shield team physicians from some of the pressures that may corrupt their judgment in treating the individual player as a patient whose interests are central to the physician.

Four general duties govern sports medicine, and they are summed up by the acronym POPE.³⁰ I use the acronym POPE to capture the seriousness of the task of helping sports doctors minimize their conflicts of interest. It is a collection of possible strategies that, taken together, reduce the risks of sports medicine conflicts for both player and doctor. These duties are to:

Protect athletes from injury, re-injury, or permanent disability, placing their welfare over that of the team or other competing interests;

Offer candid and full disclosure as to the nature and extent of injuries and the consequences of returning to play;

Practice good medicine, as defined by practice guidelines and consensus statements; and

Enable players to avoid unnecessary risks, both by helping them understand what proper treatment is and what risks are presented by returning to play, and by sharpening the framework for a declaration of ineligibility to play under some circumstances, removing the choice from the player as well as the team and coach.

A. *Protect Athletes from Injury, Re-injury, or Permanent Disability, Placing Their Welfare Over That of the Team or Other Competing Interests*

The physician is typically employed by the team or franchise, which places him or her in a position to receive a great deal of pressure from team management, ownership, and coaches.³¹ Because of this, the physician is often

28. *See id.* at 513; Keim, *supra* note 23, at 198–99.

29. Some recent writing includes Matthew J. Mitten, *Emerging Legal Issues in Sports Medicine: A Synthesis, Summary, and Analysis*, 76 ST. JOHN'S L. REV 5 (2002); Caldarone, *supra* note 20; DiCello, *supra* note 27; Isaacs, *supra* note 4. This *Saint Louis University Law Journal* symposium is the most recent example of the maturing of sports law as an academic specialty.

30. POPE is unrelated to the Hail Mary play in football, an offensive play where the quarterback throws the ball up in the air without really targeting any particular receiver, hoping someone on his team catches it.

31. Keim, *supra* note 23, at 212.

faced with an ethical, as well as legal, dilemma when the medical interest of his or her athlete-patient does not coincide with the interests of the team.³² “The primary responsibility of the team physician is to protect the athlete’s health and well-being[;]”³³ however, competitive pressures may tempt the physician to “focus only on the individual athlete’s capacity to perform.”³⁴

A team physician is a specialist aware of “fundamentals that all practicing specialists in sports medicine should know, based on the types of athletes” with whom the physician is involved.³⁵ He offers “special competence in sports medicine” and must conform to the “standard of care corresponding to . . . actual specialty training.”³⁶ He is first and foremost a physician, bound to both ethical standards of conduct and medical standards of practice.

The standard of sports medicine care has often been hard to establish. For example, in *Zimbauer v. Milwaukee Orthopaedic Group, Ltd.*,³⁷ a pitcher for the Milwaukee Brewers sued the team’s doctor, club, and medical clinic for negligent misdiagnosis and treatment.³⁸ He had a complex shoulder injury, experiencing substantial pain and undergoing arthroscopic surgery and capsular shift repair.³⁹ He was then diagnosed with a possible torn rotator cuff.⁴⁰ The court noted that his “occupation as a pitcher invoked particular concerns that fall within the specialized realm of sports medicine: the appropriate level of pain [he] could expect to experience and physical therapy tailored to his profession as a major league pitcher.”⁴¹ The plaintiff’s experts simply failed to show an appropriate sports medicine standard of care or breach.⁴²

Other cases, however, have demonstrated judicial comfort with evaluating medical standards in light of the particular risks of sports. Some sports are more dangerous than others. Boxing, football, and even skiing rank high on the list of sports that inflict long-term damage to competitors, often devastating damage or death. In *Rosensweig v. State*,⁴³ the court found as a matter of law that the physician had complied with the applicable standard of care by conducting a standard examination which failed to reveal a prior brain injury, noting that the boxer’s medical history failed to show any symptoms of

32. *Id.* at 212–13.

33. *Id.* at 214.

34. *Id.* at 213.

35. *Id.* at 202 (internal quotation omitted).

36. Keim, *supra* note 23, at 202.

37. 920 F. Supp. 959 (E.D. Wis. 1996).

38. *Id.* at 962.

39. *Id.*

40. *Id.*

41. *Id.* at 965.

42. *Zimbauer*, 920 F. Supp. at 965.

43. 171 N.Y.S.2d 912 (N.Y. App. Div. 1958).

concussion or brain injury.⁴⁴ Some expert physicians had testified that the boxer should not have been medically cleared because he had been knocked out in a prior fight, but the court characterized the examining physician's clearance recommendation as an honest error of judgment.⁴⁵ Nonetheless, it was an error, and the next case is unlikely to be described as an "honest" one, thereby raising the bar for future cases of boxer evaluations prior to a match. In *Classen v. Izquierdo*,⁴⁶ by contrast, the New York Supreme Court ruled that a ringside physician's refusal to stop a boxing match in which a participant received several blows to the head and died from his injuries might be malpractice.⁴⁷ The court noted that a physician has a duty to conform to "good and accepted standards of medical care" in determining whether an athlete should continue participating in a sport.⁴⁸ A third example is *Mikkelsen v. Haslam*,⁴⁹ where the plaintiff successfully alleged that a physician negligently provided her with medical clearance to snow ski after hip replacement surgery.⁵⁰ The jury found the physician negligent based on undisputed testimony that advising a total hip replacement patient that skiing is permissible "is a departure from orthopedic medical profession standards."⁵¹

Sports medicine is becoming a recognized specialty, with more medical boards now offering board certification in sports medicine.⁵² While older case law did not recognize sports medicine, that is clearly changing.⁵³ Some of the Consensus Statements regarding good practice are strongly phrased and allow

44. *Id.* at 914.

45. *Id.* at 913–14.

46. 520 N.Y.S.2d 999 (N.Y. Sup. Ct. 1987).

47. *Id.* at 999, 1002.

48. *Id.* at 1002.

49. 764 P.2d 1384 (Utah Ct. App. 1988).

50. *Id.* at 1385–86.

51. *Id.* at 1386.

52. See *Get the Facts: Orthopaedic Sports Medicine Subspecialty Certification*, SPORTS MED. UPDATE (Am. Orthopaedic Soc. for Sports Med., Rosemont, Ill.), May–Jun. 2003, at 8, available at <http://www.sportsmed.org/secure/reveal/admin/uploads/documents/SMU2003MayJun.pdf> (reporting that the American Board of Orthopaedic Surgery now offers board certification in sports medicine).

On March 20, 2003, the American Board of Medical Specialties approved subspecialty certification in orthopaedic sports medicine, which will be administered by the American Board of Orthopaedic Surgery (ABOS). AOSSM applauds the decision as a critical step forward that will ultimately elevate the level of postgraduate education specific to the field. . . . [T]he ABOS-proposed list of criteria for certification can be found on the Society website, www.sportsmed.org.

Id.

53. See, e.g., *Fleischmann v. Hanover Ins. Co.*, 470 So.2d 216, 217 (La. Ct. App. 1985) (noting that sports medicine is not a recognized medical subspecialty).

a physician to invoke them as a shield to deflect the strong pressures directed at his decisions.⁵⁴

B. Offer Candid and Full Disclosure As to the Nature and Extent of Injuries and the Consequences of Returning to Play

Players may understand clearly the risks of re-injury or further damage if they play with existing injuries. At times the physician in that situation may lack the power to remove the player from play. But more often we fear that team physicians, totally invested in the team's success (and their continued employment), may hold back critical risk information from patients.⁵⁵

The case of *Krueger v. San Francisco Forty Niners*⁵⁶ provides one of the best articulated duties imposed judicially on team doctors in this situation. Charlie Krueger filed a complaint against his former employer, the San Francisco Forty Niners, for fraudulent concealment of medical information.⁵⁷ Krueger asserted in his claim that neither the adverse effects of steroid injections or the true nature and extent of the damage to his knee were disclosed to him.⁵⁸ He sued for fraud or deceit under California Civil Code Sections 1709 and 1710.⁵⁹ "Section 1709 provides that '[o]ne who willfully deceives another with intent to induce him to alter his position to his injury or risk, is liable for any damage which he thereby suffers.'"⁶⁰ Section 1710(3) "defines deceit as '[t]he suppression of a fact, by one who is bound to disclose it or who gives information of other facts which are likely to mislead for want of communication of that fact.'"⁶¹

Fraud or deceit requires proof that there was "a misrepresentation or suppression of a material fact; knowledge of any falsity; intent to induce

54. See, e.g., Team Physician Consensus Statement, http://www.sportsmed.org/secure/reveal/admin/uploads/documents/CS_TeamPhysician.pdf (last visited Oct. 10, 2005).

The principal responsibility of the team physician is to provide for the well-being of individual athletes—enabling each to realize his/her full potential. The team physician should possess special proficiency in the care of musculoskeletal injuries and medical conditions encountered in sports. The team physician also must actively integrate medical expertise with other healthcare providers, including medical specialists, athletic trainers, and allied health professionals. The team physician must ultimately assume responsibility within the team structure for making medical decisions that affect the athlete's safe participation.

Id.

55. See Caldarone, *supra* note 20, at 146.

56. 234 Cal. Rptr. 579 (Cal. Ct. App. 1987).

57. *Id.* at 580.

58. *Id.* at 581.

59. *Id.* at 582.

60. *Id.* (quoting CAL. CIVIL CODE § 1709 (1987)).

61. *Krueger*, 234 Cal. Rptr. at 582 (quoting CAL. CIVIL CODE § 1710(3)).

reliance; actual and justifiable reliance; and resulting damages.”⁶² Section 1710 mandates that the concealment is not fraud unless there is a fiduciary relationship.⁶³ The court in *Krueger* noted that “[t]he relationship between physician and patient is fiduciary in nature and creates a duty to disclose.”⁶⁴ It found that the team physicians failed to tell Krueger about possible adverse effects of steroid injections, the nature and extent of his left knee damage, and the extent of damage revealed by x-rays of his left knee.⁶⁵ “[H]e thereafter developed calcification in the knee and suffered greater pain than had been the case before the surgery.”⁶⁶ He continued playing with pain and medical treatment until he retired.⁶⁷ He then began to have chronic trouble with the knee. He ended up suffering from “traumatic arthritis and a crippling degenerative process in the left knee,” unable to stand up for prolonged periods or to run or walk on stairs without severe pain.⁶⁸ “His condition [was] degenerative and irreversible.”⁶⁹

Krueger had asked to see his medical records and then learned that his physicians had known for many years that playing football would make his knee worse or permanently damage it.⁷⁰ He also thought that some treatments for his knee had never been recorded in his medical chart.⁷¹ And he was never told that he should stop playing or even that playing would aggravate the condition.⁷²

The Court of Appeals indicated that the critical question was not whether the team physicians withheld information from Krueger, but instead “whether full *disclosure* of his medical condition was ever made to Krueger.”⁷³ The court stated that a “physician cannot avoid responsibility for failure to make full disclosure by simply claiming that information was not withheld.”⁷⁴ While the defendants produced testimony that the physicians treating Krueger told him of the general nature of his injury and did not conceal certain information from him, there was no evidence that Krueger was informed of the continuing risks associated with his injuries.⁷⁵

62. *Id.*

63. *Id.* at 582–83.

64. *Id.* at 583.

65. *Id.* at 582–83.

66. *Krueger*, 234 Cal. Rptr. at 582.

67. *Id.* at 581.

68. *Id.* at 582.

69. *Id.*

70. *Id.* at 581–82.

71. *Krueger*, 234 Cal. Rptr. at 581.

72. *Id.*

73. *Id.* at 583.

74. *Id.*

75. *Id.*

The court held that the physician wanted to keep Krueger in play, and “consciously failed to make full, meaningful disclosure to him respecting the magnitude of the risk he took in continuing to play a violent contact sport with a profoundly damaged knee.”⁷⁶ The court found that the physician’s “claim of no concealment cannot be substituted for the professional warnings to which Krueger was . . . so clearly entitled.”⁷⁷ It was in the blatant failure to disclose, viewed in the light of the team’s obvious and compelling interest in prolonging Krueger’s career, that the court found “the intent requisite for a finding of fraudulent concealment.”⁷⁸

The court found that patients are “entitled to rely upon physicians for full disclosure of material medical information.”⁷⁹ The team physician contended that Krueger “was or should have been cognizant of the seriousness and permanent nature of the injury to his left knee,” and therefore Krueger made his own decision to keep playing.⁸⁰ However, the court held that Krueger was entitled to rely upon the physicians for medical treatment and advice regarding his decision to play without consulting outside sources or undertaking independent investigation.⁸¹

Informed consent and the duty to disclose are closely related. The American Medical Association’s Code of Medical Ethics, Opinion 8.08 on Informed Consent, states: “The patient’s right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice.”⁸² A physician has a duty to disclose the treatment options available to a patient and the associated risks and benefits.⁸³ This full disclosure may be shortchanged, however, given the team doctor’s conflicted obligations to the player and the team.

The Code of Medical Ethics Opinion 10.03 on the Patient–Physician Relationship in the Context of Work-Related and Independent Medical Examinations addresses the patient–physician relationship under a similar conflict-of-interest situation in which a physician is employed by the company that requires a medical examination of a person.⁸⁴ The situation is analogous to that of the team physician; in both, the patient–physician relationship is atypical because the person receiving the treatment is distinct from the person

76. *Krueger*, 234 Cal. Rptr. at 584.

77. *Id.*

78. *Id.*

79. *Id.*

80. *Id.*

81. *Krueger*, 234 Cal. Rptr. at 584.

82. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AM. MED. ASS’N, CODE OF MEDICAL ETHICS, § 8.08 (2004–2005), available at http://www.ama-assn.org/apps/pf_new/pf_online?f_n=resultLink&doc=policyfiles/HnE/E-8.08.HTM&s_t=informed+nth=4&.

83. *Id.*

84. *Id.* § 10.03.

or entity who requests and pays for the services—i.e., the person’s employer or prospective employer. Opinion 10.03 states that the physician employed by the company “has a responsibility to inform the patient about important health information or abnormalities that he or she discovers during the course of the examination.”⁸⁵ Additionally, “the physician should ensure to the extent possible that the patient understands the problem or diagnosis.”⁸⁶ This Opinion affirms that, when faced with a conflict of interest such as this, the physician must satisfy the obligations of the patient–physician relationship, including being an advocate for the patient.⁸⁷

Krueger and the AMA’s Code of Medical Ethics mandate that a team doctor must “honestly inform the athlete as to his or her true medical condition, and take affirmative steps to ensure that the athlete understands the potential consequences of playing with a particular medical condition.”⁸⁸ A sports player is entitled to rely on the physician’s advice without concern that the physician is placing the team’s interest above patient care.⁸⁹ The team doctor may be the only doctor a player ever sees about an injury and he must be able to trust the physician to properly treat the injury and to provide honest and complete information about the player’s long term health prospects.⁹⁰

C. *Practice Good Medicine, As Defined By Practice Guidelines and Consensus Statements*

American physicians have in recent years put forth substantial efforts toward standard-setting, specifying treatments for particular diseases. Clinical practice guidelines (also referred to as practice parameters and clinical pathways) have been developed by specialty societies such as the American Academy of Pediatrics; by the government, through the Agency for Health Care Policy and Research (AHCPR); and by individual hospitals in the clinical setting.⁹¹ Such guidelines are sets of suggestions, described in decision rules, based on current medical consensus on how to treat a certain illness or condition.⁹² The Institute of Medicine has defined clinical guidelines as “systematically developed statements to assist practitioner and patient

85. *Id.*

86. *Id.*

87. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, *supra* note 82, § 10.03.

88. Caldarone, *supra* note 20, at 141.

89. *Id.* at 142.

90. *Id.*

91. See generally INST. OF MED., CLINICAL PRACTICE GUIDELINES: DIRECTIONS FOR A NEW PROGRAM (1990); Arnold J. Rosoff, *The Role of Clinical Practice Guidelines in Health Care Reform*, 5 HEALTH MATRIX 369, 369–74 (1995); John Ayres, *The Use and Abuse of Medical Practice Guidelines*, 15 J. LEGAL MED. 421, 436–38 (1994).

92. Rosoff, *supra* note 91, at 370.

decisions about appropriate health care for specific clinical circumstances.”⁹³ They are “standardized specifications for . . . using a procedure or for managing a particular clinical problem.”⁹⁴

Clinical practice guidelines, so long as they are developed by an expert witness, are allowed in evidence to help establish the standard of care. They can also be used to impeach the opinion of an expert witness.⁹⁵ A national standard of practice does not exist for many procedures and tools, and the “highest and best” practice may not be the safest or most effective in the long run. Substantial regional variations exist in the use of many procedures, with no apparent differences in outcome (life expectancy, morbidity, days missed from work).⁹⁶ Different practice styles exist in different regions, and even within states, based on a local concept of good practice. Practices may continue to be used by physicians out of sheer inertia, or because reimbursement reinforces their use, or because it makes a physician at least feel like she is doing something for a patient.

Clinical guidelines raise difficult legal questions, since they potentially offer an authoritative and settled statement of what the standard of care should be for a given treatment or illness. A court has several choices when such guidelines are offered in evidence. Such a guideline might be evidence of the customary practice in the medical profession. A doctor practicing in conformity with a guideline would be shielded from liability to the same extent as one who can establish that she or he followed professional custom. The guideline acts like an authoritative expert witness or a well-accepted review article.⁹⁷ Using guidelines as evidence of professional custom, however, is

93. INST. OF MED., *supra* note 91, at 8.

94. Rosoff, *supra* note 91, at 370 (internal quotation omitted).

95. See, e.g., *Roper v. Blumenfeld*, 706 A.2d 1151, 1155–56 (N.J. Super. Ct. App. Div. 1998). In *Roper*, the defendant used the 1992 *Parameters of Care for Oral and Maxillofacial Surgery: A Guide of Practice, Monitoring and Evaluation* in order to cross-examine the plaintiff’s expert and to examine his expert. *Id.* As used to impeach, it was permissible to counter the doctor’s opinion that because plaintiff sustained an injury during defendant’s failed attempt at extraction, defendant must have deviated from the standard of care because such injury is not a medically accepted risk of the procedures he performed. As to this claim, the article is quite relevant for it lists as a known risk and complication of “erupted” teeth “[o]ral-facial neurologic dysfunction.”

Id.

96. See generally John Wennberg & Alan Gittlesohn, *Small Area Variations in Health Care Delivery*, 182 SCIENCE 1102 (1973); Pamela Paul-Shaheen et al., *Small Area Analysis: A Review and Analysis of the North American Literature*, 12 J. HEALTH POL. POL’Y & L. 741 (1987).

97. Andrew L. Hyams et al., *Medical Practice Guidelines in Malpractice Litigation: An Early Retrospective*, 21 J. HEALTH POL. POL’Y & LAW 289, 293–94 (1996) [hereinafter *Early Retrospective*].

problematic if they are ahead of prevailing medical practice. A guideline could also serve as evidence of a “respectable” minority practice.⁹⁸

Guidelines have already had an effect on settlement patterns in areas of litigation such as medical malpractice.⁹⁹ Plaintiffs have used such guidelines to their advantage in malpractice cases, particularly the guidelines of the American College of Obstetricians and Gynecologists (ACOG).¹⁰⁰ Such guidelines provide a particularized source of standards against which to judge the conduct of the defendant physician. A widely accepted clinical standard may be presumptive evidence of due care, but expert testimony will still be required to introduce the standard and establish its sources and its relevancy. A guideline could thus establish negligence per se or at least a rebuttable presumption that could then be countered with evidence.¹⁰¹

Guidelines are shields to repel pressure from coaches, family, team management, fans, or the athlete to provide medical clearance to participate or treatment enabling immediate return to play. They reduce the uncertainty of traditional “customary practice.” Sports medicine consensus statements and guidelines have proliferated in recent years, driven in part by the publicity surrounding the deaths of young athletes due to underlying cardiac conditions.¹⁰² Such deaths have included Olympic volleyball player Flo

98. See generally *id.*; Andrew L. Hyams et al., *Practice Guidelines and Malpractice Litigation: A Two-Way Street*, 122 ANNALS INTERNAL MED. 450 (1995) [hereinafter *Practice Guidelines*].

99. *Practice Guidelines*, *supra* note 98, at 453.

100. See, e.g., *Miles v. Tabor*, 443 N.E.2d 1302, 1303 (Mass. 1982) (finding obstetrician’s failure to initiate resuscitation of infant immediately after delivery violated ACOG guidelines); *Green v. Goldberg*, 630 So. 2d 606, 609 (Fla. Dist. Ct. App. 1993) (allowing ACOG bulletin on breast cancer treatment to support expert testimony during cross-examination or to supplement an opinion of the doctor which she already formed); *Basten v. U.S.*, 848 F. Supp. 962, 967 (M.D. Ala. 1994) (citing ACOG guidelines requiring that alpha-fetoprotein screening be offered and that acceptance or rejection be documented); see also *Early Retrospective*, *supra* note 97, at 296–99.

101. See Mark R. Chassin, *Standards of Care in Medicine*, 25 INQUIRY 437, 448 (1988).

102. Barry J. Maron & Jere H. Mitchell, *26th Bethesda Conference, Introduction: Revised Eligibility Recommendations for Competitive Athletes with Cardiovascular Abnormalities*, 24 J. AM. COLL. CARDIOLOGY 848, 848 (1994) [hereinafter *26th Bethesda Conference*]; Barry J. Maron & Douglas P. Zipes, *36th Bethesda Conference, Introduction: Eligibility Recommendations for Competitive Athletes with Cardiovascular Abnormalities—General Considerations*, 45 J. AM. COLL. CARDIOLOGY 1318, 1318 (2005) [hereinafter *36th Bethesda Conference*]; Barry J. Maron et al., *Recommendations for Physical Activity and Recreational Sports Participation for Young Patients with Genetic Cardiovascular Diseases*, 109 CIRCULATION 2807, 2808, 2814 (2004), available at <http://circ.ahajournals.org/cgi/reprint/109/22/2807> (giving specific recommendations for physical activity and the risk factors for patients with genetic cardiovascular diseases and concluding that “[c]ompliance with these recommendations is evidence that a physician has satisfied these legal requirements and may form the basis of a successful defense to allegations of malpractice”); see also Team Physician Consensus Statement, *supra* note 54. The Team Physician Consensus Statement is available on the websites of the following organizations: American College of Sports Medicine,

Hyman, basketball players Pete Maravich, Hank Gathers, and Reggie Lewis, Olympic gold medal figure skater Sergei Grinko and St. Louis Cardinal pitcher Darryl Kile.¹⁰³ Hank Gathers' collapse and death in 1992 while playing for Loyola-Marymount University was one of the most prominent of such deaths.¹⁰⁴ Gathers' estate alleged that his sudden death was due to inflammatory cardiomyopathy caused by negligent reduction of cardioactive medication (administered for ventricular tachyarrhythmias) to sub-therapeutic doses as a way to continue and advance his career.¹⁰⁵ He was one of the best college players in the country and a likely early professional draft choice.¹⁰⁶ He insisted on progressively reducing the dosage of beta-blocker in order to perform at his highly skilled level, over six weeks, and his physician acquiesced.¹⁰⁷ He then died during a nationally televised basketball game.¹⁰⁸ The suit alleged that the failure to remove him from active play in line with *Bethesda #26* recommendations constituted negligence.¹⁰⁹ The case was

<http://www.acsm.org/pdf/teamphys.pdf>; American Academy of Family Physicians, <http://www.aafp.org/x19525.xml>; American Academy of Orthopaedic Surgeons, <http://www.aaos.org/wordhtml/papers/advistmt/1021.htm>; American College of Sports Medicine, <http://www.acsm.org/pdf/teamphys.pdf>; and American Orthopaedic Society for Sports Medicine, http://www.sportsmed.org/secure/reveal/admin/uploads/documents/CS_TeamPhysician.pdf.

The objective of the Team Physician Consensus Statement is to provide physicians, school administrators, team owners, the general public, and individuals who are responsible for making decisions regarding the medical care of athletes and teams with guidelines for choosing a qualified team physician and an outline of the duties expected of a team physician. Ultimately, by educating decision makers about the need for a qualified team physician, the goal is to ensure that athletes and teams are provided the very best medical care.

Team Physician Consensus Statement, *supra* note 54. See generally Barry J. Maron et al., *Competitive Athletes with Cardiovascular Disease—The Case of Nicholas Knapp*, 339 NEW ENG. J. MED. 1632 (1998).

103. See George Vecsey, *Sports of The Times: Remembering Flo Hyman*, N.Y. TIMES, Feb. 5, 1988, at B15; Richard Sandomir, *TV Sports: The Same Pistol Pete, but Profiles Are Different*, N.Y. TIMES, Mar. 30, 2001, at D3; Lawrence K. Altman, *No Trace of Heart Medication in Gathers, Autopsy Indicates*, N.Y. TIMES, Mar. 16, 1990, at B9; Dave Anderson, *Sports of The Times: Lewis Death on Celtics' Conscience*, N.Y. TIMES, July 29, 1993, at B7; Selina Williams, *Figure Skating: Colleagues and Family Bid Grinkov Farewell*, N.Y. TIMES, Nov. 26, 1995, § 8 (Sports), at 8; Lawrence K. Altman, *Heart Disease Can Hit Even the Young, like Kile*, N.Y. TIMES, June 25, 2002, at D1.

104. See David L. Herbert, *Practice Guidelines Take Center Court*, 24 PHYSICIAN & SPORTSMED., Mar. 1996, at 81.

105. See Isaacs, *supra* note 4, at 148–49, 168–69.

106. See Herbert, *supra* note 104, at 81.

107. Isaacs, *supra* note 4, at 148–49, 168–69.

108. Herbert, *supra* note 104, at 81.

109. See *id.*

settled.¹¹⁰ It was however one of the first times that a violation of a clinical practice guideline was alleged in a sport injury case.¹¹¹ The allegation has since become more common in athlete lawsuits.¹¹² Another case, *Gardner v. Holifield*,¹¹³ involved the death of a college basketball player. The plaintiff presented evidence that the physician performing the screening examination did not adhere to American Heart Association (AHA) screening guidelines.¹¹⁴

The standard of care is defined by reference to a physician using the knowledge, skill, and care ordinarily possessed and employed by members of the profession in good standing, good medical practice within the area of specialty practice, and reasonable, customary, accepted care under the circumstances. Courts have recognized guidelines established by national medical associations as evidence of good medical practice, but not conclusive as to the standard of care.

D. Enable Players To Avoid Unnecessary Risks: Team or Sports Policies

Team and sport policies and guidelines that specifically address the risks of returning to play may help reduce pressures and temptations on all the parties. Many eligibility consensus statements are now available, and the deaths of young athletes will spur the further development of such statements. More important will be the recognition by professional sports team that they risk bad publicity and litigation if they don't develop policies that allow team physicians to decide when a player returns to play, without fear of repercussions. This also requires education of athletes in the long-term risks such as those suffered by Krueger and others as a counterbalance to their understandable enthusiasm to return to play. Consensus statements and clear policies for eligibility to play are a logical development in the professionalization of sports medicine. Such statements will shield team physicians from intense pressures to keep athletes in play, and they will help sports develop a strong athlete-protective environment.

110. Barry J. Maron, *Sudden Death in Young Athletes—Lessons from the Hank Gathers Affair*, 329 NEW ENG. J. MED. 55, 55 (1993).

111. Herbert, *supra* note 104, at 81.

112. See, e.g., *Knapp v. Nw. Univ.*, 101 F.3d 473, 485 (7th Cir. 1996) (ruling that national association medical guidelines (26th Bethesda Conference) can be used by college team physicians in formulating medical eligibility decisions, and upholding disqualification of an athlete with an implanted defibrillator); *Izidor v. Knight*, 117 Wash. App. 1070 (Wash. Ct. App. 2003) (unpublished) (emphasizing the merits of adherence to American Heart Association screening recommendations).

113. 639 So. 2d 652 (Fla. Dist. Ct. App. 1994).

114. *Id.* at 653.

IV. CONCLUSION

Sports medicine, like military medicine, exposes physicians to more conflicts of interest and pressures than most areas of medical practice. The lure of a lucrative and celebrity-oriented medical practice has driven sports medicine forward into a growing specialty apace with the commercialization and turn to big business of professional athletics. At the same time, new specialty organizations and groups have developed to guide this new specialty. And the courts, faced with obvious conflict situations, have in a range of cases set boundaries for acceptable behavior of these doctors.

There may be other solutions that work over time to reduce conflicts: having physicians rotate in and out of practice with a team; having them employed by an independent body, such as a player's union or professional sports league, rather than by the team in order to avoid immediate and direct conflicts; or at least having explicit agreements that define the boundaries of the relationship of team doctor and team more precisely than is typically done today.¹¹⁵ My suggestion is a more limited one, reflecting practices that are now evolving and standards that courts are proving to be comfortable imposing. Practice guidelines and consensus statements guide physicians and also arm them with a defense against pressure to return injured players to play at any cost. The POPE duties remind the sports physician that his or her relationship to players is a "sacred trust" that requires scrupulous attention to the interests of the player as the central goal of this physician-patient relationship.

115. See Calandrillo, *supra* note 18, at 203-07.

